STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155365	A. BUILDING 01 B. WING	04/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASH SKILLED CARE CENTER	710 N EAST STREET WABASH, IN46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/05/11 Facility Number: 000256 Provider Number: 155365 AIM Number: N/A Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Wabash Skilled Care Center was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was located on the third floor of a three story building with a basement determined to be of Type I (443) construction and	K0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies.The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is May 5, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	the third floor was fully sprinklered. This survey will include the entire third floor due to the lack of two hour separation between the Skilled Care Center and the remaining third floor occupancy. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 25 and had a census of 11 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/08/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0033	Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1			
SS=E	Based on observation and	K0033	K033Addendum to the Plan of	07/05/2011

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	interview, the facility failed to maintain 2 of 3 exit stairways in accordance with LSC 7.7.1 and LSC 7.7.2. LSC 19.2.7 requires discharge from exits shall be in accordance with Section 7.7. LSC 7.7.1 requires exits to discharge to the public way or an exterior exit discharge. LSC 7.7.2 allows no more than 50 percent of exits to discharge into an area on the level of exit discharge. This deficient practice could affect all residents, staff and visitors evacuated from the north and south exit stairways in the event of an emergency. Findings include: Based on observations with the Leader of Facilities Services on 04/05/11 from 1:45 p.m. to 2:20 p.m., the north and south stairways discharged onto the first floor and not directly to the exterior of the building. This was confirmed by the Leader of Facilities Services during an interview at the time of observations. 3.1-19(b)		Correction for survey dated 4/5/11.Please allow this Addendum as well as our Plan of Correction to serve as our Credible Allegation of Compliance.The request for an extension of time completion date should be 7/5/11.K 033The facility is requesting an extension of time of 90 days to correct this citation. The extension is necessary as the lead time to get the required doors into the facility could be as much as 8 weeks. With the structural changes that need to take place, it will take approximately 90 days to complete. The facility will reinforce to the staff at a staff meeting on 4/21/11 to continue to use the East Exit Stairwell, which does exit directly outside, located on the third floor in case of an evacuation.It is the intent of this facility to ensure that at least 50% of the stairwell exits will discharge to the public way or to an exterior exit discharge.To comply with the standard that 50% or greater of all stairwell exits will exit directly to the outside or through an exit discharge the following will be completed. Sprinkle all areas on the first floor that are not currently sprinkled and renovate the north stairwell exit as to create an exit discharge passage way from the stairwell to the exit that will be of the same rating as the stairwell.Once structural changes have been made the problem will no longer exist. The staff will	

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			continue being inserviced annually on the evacuation procedure. Monthly renovation progress will be reported to the WSCC Health Facility Administrator and Director of Nursing by the Leader of Facilities Services. A summary will be presented to the Quality Assurance Committee at the quarterly QA Meeting.	
K0061	Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1			
SS=F	Based on observation and interview, the facility failed to ensure 3 of 3 manual water shut off valves were electronically supervisor. This deficient practice affects all occupants. Findings include: Based on observation with the Leader of Facilities Services on 04/05/11 at 2:20 p.m., three water shut off valve were chained and padlocked at the sprinkler riser. Wiring was observed at each of the shut off valves but was not connected. Based on an interview with the Leader of Facilities Services at the time of observation, he questioned these shut off valves but was told by his	K0061	It is the intent of this facility to ensure that the water shut off valves will be electronically supervised.One valve has been found to be out of compliance. Two of the three valves cited in the deficient practice are actually service valves, therefore they are not required to be monitored. The control valve found not to be in compliance will be connected to the supervisory monitor.All residents have the potential to be affected. The control vavle will be connected to the supervisory monitor which is monitored monthly by the Leader of Facilities Services or his designee. Once the control valve is connected to the supervisory monitor, it will be monitored monthly by the Leader of Facilities Services or his designee. The Leader of Facilities Services will submit a report to the Quality Assurance Committee quarterly.	05/05/2011

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	contract providers he only needed the chain and padlock the valves in the open position. 3.1-19(b)			
K0144	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			
SS=F	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998	K0144	It is the intent of this facility to ensure the emergency generator will be equipped with a remote manual stop. An emergency stop button for the emergency generator will be installed outside of the generator room.All residents have the potiential to be affected. The emergency button will be installed and then will be monitored monthly by the Leader of Facilities Services or his designee.The emergency stop button will be monitored monthly by the Leader of Facilities Services or his designee. The Leader of Facilities Services will submit a report quarterly to the Quality Assurance Committee.	05/05/2011

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	Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Leader of Facilities Services on 04/05/11 during a tour of the facility from 12:30 p.m. to 2:40 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Leader of Facilities Services at 2:05 p.m., the generator engine was rated over 100 horsepower. 3-1.19(b)			